

2022

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Recognizing and Responding to Abuse in Later Life: Feedback from Virginia's Frontline

By Sarah Marrs, Ph.D., and Courtney O'Hara, M.S.

Learning Objectives

- 1) To describe a research project aimed at understanding the recognition of and response to abuse in later life in the greater Richmond area
- 2) To discuss the structural factors that contribute to underidentification and under-resourcing of services that address abuse in later life
- 3) To discuss the relationship between ageism and abuse in later life

It is estimated that about 10% of adults aged 60 years and older will be victims of abuse (Acierno et al., 2010). For each case of elder abuse that gets reported, there may be as many as 25 cases that are never reported. In Virginia, cases of both reported and substantiated elder abuse has been growing steadily (DARS, 2021). For example, the number of calls received by the state Adult Protective Services hotline in Virginia saw a 23% increase from fiscal year 2020 to fiscal year 2021. This is in part due to the COVID-19 pandemic, which led to a stark increase in the number of cases of elder abuse. However, this trend was evident even before the pandemic and is also the result of an increase in Virginia's older adult population, which is expected to continue growing. In fact, as the population of older adults in our world continues to grow, it is estimated that one in five people in Virginia will be older than 65 years by the year 2030. That said, the current trends of increasing cases of abuse are only expected to worsen and intensify.

One way to begin reversing these trends is to engage in research aimed at deepening our understanding of the current landscape regarding abuse in later life. Much of the research that has been conducted to date is quite limited in scope and not completely accurate in portraying the picture of abuse in later life. For example, adults with disabilities and adults living with dementia are substantially more likely to be victims of abuse but are often not included in research studies for various reasons, including but not limited to, lacking the ability to give informed consent. Similarly, adults residing in long term care facilities are not well-represented in the literature but are also more likely to be abused. Unfortunately, many grants available for abuse in later life work actually prohibit grantees from conducting empirical research. This has left us with few training curricula that are evidence-based and a poor understanding of the needs of those best poised to intervene and prevent abuse as well as a limited understanding of current knowledge, practices, and attitudes towards abuse in later life. To begin "taking the temperature" in Virginia regarding elder abuse, the Virginia Center on Aging (VCoA) decided to seek, and were awarded, a VCU Presidential Research Quest (PeRQ) Foundation Grant that would enable us to conduct research in the Greater Richmond area. The grant team is led by Sarah Marrs, Ph.D., an Assistant Professor in the VCoA and Department of Gerontology at VCU. Dr. Marrs brings a strong background of conducting both qualitative and quantitative research to the team in addition to

experience with training and research focused on workforce enhancement in healthcare. The Co-Investigator on this project is Courtney O'Hara, Director of the Abuse in Later Life Project at the VCoA. O'Hara is a skilled curriculum developer who has extensive experience in training about elder mistreatment and has helped develop enhanced multidisciplinary teams to address elder abuse. Other team members from the VCoA include Kim Ivey, the project's coordinator, and Maddie McIntyre, a research analyst who has assisted with data analysis. Two students, one undergraduate and one doctoral student, were also recruited to assist with analysis of the qualitative data. While she is no longer with VCU, Ruth Anne Young, a former project manager with VCoA, was also instrumental in getting this project submitted and initially implemented.

The purpose of our PeRQ project, which is still underway, is to explore recognition of and response to cases of abuse in later life. Specifically, we wanted to learn more about knowledge, current practices, and attitudes surrounding abuse among three populations of Virginia's frontline workforce: aging and victim service providers, healthcare professionals, and law enforcement personnel. To do this, we designed a project that would take place in two phases: a qualitative phase and a quantitative phase. During the first phase - the qualitative phase - we conducted a series of focus groups and one-on-one interviews with people from each of our three populations. This phase of the project has concluded. Phase two - the quantitative phase - is still in progress; the purpose of the second phase of the project is to create a survey using the findings from the first phase that can be distributed more broadly across Virginia to people working in these three fields. The focus of this case study will be on the first, qualitative phase of the project.

During the fall and winter of 2020 and the spring of 2021, we were able to speak with representatives of aging and victim service providers ($n = 9$), healthcare ($n = 7$), and law enforcement ($n = 8$) who worked in the greater Richmond area in either an urban ($n = 12$), suburban ($n = 9$), or rural setting ($n = 3$). Disciplines were not mixed during focus groups to help ensure that our participants felt safe and comfortable enough to speak freely since these topics can be very sensitive. All focus groups and interviews were led by Annie Rhodes, a research analyst with the VCoA, to make sure there was consistency across conversations and promote rigor of our research design. The conversations were loosely guided by the following questions:

- 1) What does it mean to be old?
- 2) What does it mean to be abused?
- 3) What does abuse of older adults look like?
- 4) What role does [your profession] play in addressing abuse in later life?
- 5) What role does [other profession(s)] play in addressing abuse in later life?
- 6) If you suspect an older adult has been abused, neglected, or exploited, what is your protocol for responding?
- 7) Have you ever collaborated/coordinated with another service provider to respond to a case of abuse in later life?

All focus groups and interviews were recorded and transcribed; these transcriptions, or typed versions of the conversations, were then analyzed to identify themes within the

data. Three major themes emerged from our focus group and interview data, all of which point to areas needing future research and/or attention: Increasing capacity, prevention and coordination, and ageism.

Increasing Capacity

All of our participants highlighted a real need to build the capacity of those trained, qualified, and positioned to address elder abuse. This includes increasing training and education opportunities. We learned from participants that most of them did not receive any training on elder abuse in their educational programs. For those who did have training, they described it as something that was “glazed over,” not a topic given any particular priority or emphasis. For instance, when asked if they had ever received any training on elder abuse, one healthcare worker responded:

No. I did a master's in hospital administration and that never came up. The only time that I can think of actually completing a training on elder abuse was when I was volunteering. Other than that, that was something I sought out myself. There wasn't anything that was presented to me.

Over and over, we heard participants tell us they either had no training or “there’s a little tiny section on it” when it comes to abuse in later life. Even rarer are issues related to general aging covered in any educational and/or training programs for these frontline professionals.

Another important way in which we need to increase the capacity of this workforce is to increase the resources devoted to and available for responding to elder abuse. Our participants are keenly aware of how understaffed and under-resourced their offices are. One of our aging/victim service providers summarized it perfectly, saying:

It makes me feel that there's little value on older adults...I will just say that it's probably about six of us APS workers, compared to over 40...on CPS...and so that just makes me feel like they're saying 'Well, they've lived their life. They don't need anybody to advocate. They're not going to be here much longer anyway' and I think that's just awful.

From the perspective of law enforcement officers, the understaffing of organizations such as Adult Protective Services can really impede their capacity for intervening when abuse has occurred. For example, one law enforcement officer said:

In our jurisdiction, the volume we deal with is always a problem with social services. Everybody needs more manpower. In a perfect world, if everybody was fully staffed, things would work better.

Substantially increasing our investments in resources and education for frontline personnel would play an important role in improving the response to abuse in later life.

Prevention and Coordination

A sense of feeling helpless was pervasive in our data. Current policies and practices primarily allow the workforce to **respond** after abuse has occurred when, in many cases, the abuse could actually be **prevented**. Several law enforcement personnel discussed being in circumstances where they could anticipate a situation would escalate to abuse. Unfortunately, the only option available to them is to sit and wait until something terrible happens to an older adult before they can then legally respond. Law enforcement participants also face challenges when it comes to linking various systems and community-based organizations to help those in need. For example, one law enforcement representative described the following situation:

We could be on the phone with mental health, APS, DSS [Department of Social Services], whoever, begging them to do something to help us get someone out of a situation, and we're there, we're seeing it, we're saying hey, this isn't safe, or hey, they need these resources, and it's almost like they're the ones that are shrugging their shoulders going well, we can't do anything so you've just got to leave them or you've just got to take them to the hospital and we'll deal with it later.

Another painted a similar picture, referring to themselves as “a taxi to the hospital,” saying the following of incidents involving group homes and/or long-term care facilities:

They'll call the police because an ambulance is expensive. They don't want to pay that ambulance bill, but if you say he's having thoughts of suicide and wants to go to the hospital, we show up, we take them to the hospital...it is something that I don't mind doing, but a lot of times when workers call, it's because they have six or seven other people on their hands, and they're the one worker that night, and there's no oversight. I don't know if APS would do anything. I don't think there's any master list of where all these nursing homes, or group homes, or even homes for people with mental disabilities, even for people who aren't elderly are. I don't think anyone has that master list and does checks to make sure they're safe or anything like that. Somehow the police find out if there's abuse from some random source, and we show up and call APS. That's the only check and balance we have in our system.

The healthcare providers we spoke with also find the current landscape difficult to navigate. One healthcare provider echoed the concerns related to preventing versus responding to abuse, saying:

And also, I think they're really looking for the crisis, and I think that's sometimes the problem. We don't want to get to the point where we've got [a crisis]. Unless people are in crisis, it's actually harder to handle the situation than if you can detect the rising risk and try to help.

Complicating matters, policies and rules seem to be ever-changing, making it difficult for them to keep track of appropriate avenues for reporting abuse, as evidenced by the following quote:

...the rules never seem to stay the same and so it's really hard to help people when the rules keep changing and I can't stay up on them, so that's frustrating...it would be so nice...if there were some societal, structural appreciation for the aging, but a lot of the policies seem to be made by the generation before that hasn't gotten to aging.

It's clear that the current infrastructure is not serving our frontline personnel or older adults at risk of abuse. Shifting the focus from responding to preventing abuse and creating more coordinated systems and policies would empower everyone poised to address elder abuse and keep more people safe.

Ageism

Within our data, ageism was present and playing two roles. First, ageist attitudes were expressed by some participants we spoke with. For example, one healthcare professional said:

Well, what do you expect? Sure they smell like urine and they're not caring for themselves, but they're old and that's how it goes.

This type of self-neglect or neglect on the part of someone else, is never normal, despite its normalization regarding older adults, particularly those living in nursing homes (see Taverner et al., 2016). Ageist beliefs such as this can actually stifle our recognition of abuse, such as in this instance described by a law enforcement officer:

The other side of that with healthcare, we get a lot of APS-generated calls, where something will start in the emergency room. The patient will be transferred to another facility or a more specialized unit. The ER will report something. The worst injury I've ever seen in my life, it was definitely abuse. They make a report, it comes to us, we investigate it. Then we talk to the next doctor, the specialist, and the specialist is like, 'you know, for their age and their mobility, it's a completely normal injury.' ...there's a disconnect between intake and the specialists.

Our participants were quite clear about - and did not hesitate to discuss - how little our society values older adults. Not only does this lead to harmful oversights on the part of the workforce, but we can see the impacts of ageism at the structural level when we examine the policy and funding structures around abuse, as discussed in the previous two sections. This is evident not only by recognizing that many either do not value older adults or hold dangerous, stereotypical, and inaccurate beliefs about them, but also by the fact that our workforce tasked with intervening in cases of elder abuse do not have

the resources and knowledge needed to effectively do their job. An aging/victim service provider stated:

Well I think there's a difference in how people look at child abuse and adult abuse. With Child Protective Services, they have the clout to do things: remove the child, more legal actions. With elder abuse, there are no laws. They don't have any...power behind them to force the issue to be looked at."

This is clear to healthcare professionals, as well, as evidenced by the following quote:

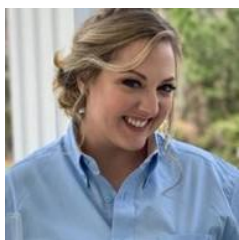
Generally, I definitely think that younger patients are prioritized across healthcare, their health, and you see that in funding, too, like for children's hospitals.

By not adjusting the way we think about older adults and elderhood, we are actively contributing to the problem, not addressing it. This is echoed at the national level, where per victim of abuse, \$5,920 is spent per child abuse victim, \$240 per domestic abuse victim, and \$1.91 is spent per victim of elder abuse. Addressing these problematic attitudes towards aging and older adults at the individual and structural level plays a major role in protecting the safety and well-being of all older adults.

Conclusions and Next Steps

A critical step toward breaking the link between ageism and abuse is to invest in research that specifically aims at understanding ageism as well as developing interventions to reduce ageism. The more we understand ageism, the better we can step in to reduce its impact on our world. Similarly, investing in empirical research on abuse in later life will also lead to the development of more effective and evidence-based training for our frontline personnel. As we continue this important work, we intend to expand this research beyond Richmond to the entire Commonwealth of Virginia with the ultimate goal of being able to develop much-needed training for frontline workers, older adults, and caregivers of adults.

About the Authors



Sarah Marrs, Ph.D., joined VCU's Virginia Center on Aging in 2016 as an Assistant Professor. She teaches statistics and research methodology in VCU's doctoral program in Health-Related Sciences and oversees a faculty and clinician professional development program focused on interprofessional geriatrics. Her research interests focus on the impact of ageism on healthcare, professionals' recognition of and response to abuse in later life, and geriatrics workforce enhancement through interprofessional training. She is the

Principal Investigator on the PeRQ project described in this case study.



Courtney O'Hara joined VCU's Virginia Center on Aging in 2015 and now serves as the Director of Abuse in Later Life programming, which focuses on developing and implementing effective responses to elder mistreatment. Additionally, she serves as the Principal Investigator for the Abuse in Later Life Project, funded by the Virginia Department of Criminal Justice Services. This project works with criminal justice agencies, victim services, social services, legal services programs, health care providers, the aging network & faith communities to collaboratively address the unique needs of older people who are survivors of abuse. Courtney is a skilled trainer and curriculum designer with significant experience in strengths-based leadership and project management.